STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		COMPLETED
		155417	B. WING		04/05/2011
NAME OF P	PROVIDER OR SUPPLIER	}	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
			I	GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG	SCOTT	SBURG, IN47170	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` ·	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE
F0000					
	This visit was	for Investigation of	F0000	This Plan of Correction const	itutes
	Complaints IN00088379 and			the written allegation of	
	_	100000377 and		compliance for the deficiencie	
	IN00088699.			cited. However, submission of Plan of Correction is not an	tnis
				admission that a deficiency ex	ists
	Complaint IN			or that one was cited correctly	/ .
	Substantiated.	Federal/state		This Plan of Correction is submitted to meet requiremen	nts
	deficiencies re	elated to the		established by state and feder	
	allegations are	e cited at F272, F279,		law.	
	F282, F312 an	nd F328.			
	,			Hickory Creek at Scottsbur desires this Plan of Correc	
	Complaint IN	00088600		to be considered the facilit	
	Substantiated.			Allegation of Compliance.	^
				Compliance is effective on	May
	deficiencies re			5, 2011.	
	_	e cited at F272, F279			
	and F312.				
	Unrelated defi	iciency cited.			
		•			
	Survey dates:	4/4 and 4/5/11			
	Sarvey dates.	1/1 4114 1/0/11			
	Facility numb	er: 000421			
	Provider numb				
	AIM number:	100288340			
	Survey team.	Jennie Bartelt, RN			
	Survey team.	John Darton, KIN			
	Census bed ty	pe:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	(X2) MULTIPLE CC A. BUILDING B. WING	00	i .	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP C GARDNER AVE SBURG, IN47170	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	SNF/NF: 33 Total: 33					
	accordance with 410	reflect state findings cited in				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPL	ETED
		155417	B. WING			04/05/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				GARDNER AVE		
HICKORY	Y CREEK AT SCOT	TSBURG			SBURG, IN47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0272	<u>-</u>	onduct initially and					
SS=D	SS=D periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.						
	each resident's fur	ictional capacity.					
	A facility must mak	ke a comprehensive					
		esident's needs, using the					
		ne State. The assessment					
	must include at lea	-					
		demographic information;					
	Customary routine						
	Cognitive patterns Communication;	,					
	Vision;						
	Mood and behavio	or patterns;					
	Psychosocial well-						
	Physical functioning	ng and structural problems;					
	Continence;						
		and health conditions;					
	Dental and nutrition Skin conditions;	onai status;					
	Activity pursuit;						
	Medications;						
	Special treatments	s and procedures;					
	Discharge potentia	al;					
		summary information					
		tional assessment					
		the resident assessment					
	protocols; and Documentation of	participation in assessment.					
İ		ervation, interview,	F0:	272	F272 It is the policy of this		05/05/2011
	and record rev	iew, the facility			facility to conduct initial an periodic comprehensive,	<u>a</u>	
	failed to ensur	e a resident's skin			accurate, standardized, and		
		completely and			reproducible assessment o the resident's functional	<u>f</u>	
		elated to a wound at			capacity, including complete		
	the dialysis fis				and consistent assessment skin, including any identifie		
	_	ice affected 1 of 4			wound at the dialysis fistula		
	residents revie	ewed related to			site and routine assessmen	<u>ıt</u>	

l i '		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155417	B. WIN	G		04/05/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	GARDNER AVE	
HICKOR	Y CREEK AT SCOT	TSBURG		SCOTT	SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	assessment of	wounds in a sample			for infection and the thrill a bruit of the dialysis fistula	
	of 9. The facil	lity also failed to			1.What corrective action wi	
	assess the resid	dent's dialysis fistula			accomplished for those	<u> </u>
	site as indicate	·			residents found to have be	<u>en</u>
					affected by the deficiency?	
		erials. The deficient			wound that was at the dialy	
	practice affect	ed 1 of 1 resident			fistula site on the right upp	<u>er</u>
	reviewed relate	ed to dialysis site			forearm of Resident F has healed. The Director of Nur	se's
	care in a samp	le of 9 residents.			will inservice all staff RNs a	
	(Resident F)				LPNs on dialysis fistula site	
	(Resident 1)				care, including assessing t	h <u>e</u>
					site every shift for	
	Findings inclu	de:			signs/symptoms of infection	<u>n</u>
					and checking the dialysis	#illo
	The clinical re	cord for Resident F			fistula site for bruits and th Dialysis fistula site	rilis.
		on 4/4/11 at 4:15			assessments and bruit & th	rill
					checks shall be done every	
	•	dent's diagnoses			shift and documented on th	<u>ie</u>
	included, but v	were not limited to,			treatment administration	
	end stage rena	l disease.			record (TAR). If the nurse fi	
					wound issues at the dialysi fistula site or an absence o	
	A. A physicia	n's order was			bruit & thrills, the resident's	_
					attending physician and leg	
		21/11 and indicated,			representative shall be noti	
	"Apply Bacitra	acin [antibiotic			of the change in condition.	_
	ointment] daily	y to blisters on LUE			The nurse will also docume	
	[left upper ext	remity]. Keep area			the assessment results white indicate a change in condit	
	covered and cl				in the resident's medical re	
		Cuii.			and on the 24 hour report.	
					2.How will the facility identi	<u>fy</u>
	Documentation	n on Nurse's Notes			other residents having the	
	failed to indica	ate an assessment of			potential to be affected by t	<u>:he</u>
	the area of the	upper arm requiring			same practice and what	
	treatment.	11 10			corrective action will be tak No other residents were	<u>sen r</u>
	u cannont.				NO Other residents were	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155417	B. WIN			04/05/2011
			P. (12)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG		1	SBURG, IN47170	
						(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE REDGEDED BY ELLI I		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)	+	IAG	affected by this practice. N	
					other resident(s) residing a	
	The Treatment	t Record for March			facility receive dialysis	<u> </u>
	2011 indicated	l an entry for "Apply			services. 3.What measures	will
		tment to blisters on			be put into place to ensure	l l
					practice does not recur? A	<u>s</u>
		ht upper extremity].			stated above the wound that	
	Keep area cov	ered and clean."			was at the dialysis fistula s	
	Documentation	n after the treatment			on the right upper forearm Resident F has healed. Dia	
	was completed	d on 3/29/11			fistula site assessments an	
	indicated, "He	· ·			bruit & thrill checks shall b	
	muicateu, 11e	aleu.			done every shift and	_
					documented on the treatme	ent_
	During observ	ation of Resident F's			administration record (TAR	
	dialysis access	s site on 4/5/11 at			the nurse finds wound issu	
	1	MDS (Minimum			at the dialysis fistula site o	
	.	`			absence of bruit & thrills the resident's attending physic	
	Data Set) Coo				and legal representative sh	
	interviewed. S	She indicated the	be notified of the change in			
	resident had a	dialysis shunt to the	condition. The nurse will also			
	upper right arr	n and attended	document the change in			
	11	times a week on			condition and any new ord	
	*				from the attending physicia	
	"	nesday, and Friday.			the resident's medical reco and on the 24 hour report.	
	The MDS Cod	ordinator indicated the			DON or designee will review	ı
	resident had w	hat was thought to be			the 24 hour report and focu	ı
	a tape burn to	the area where the			charting at least 5 days a w	ı
	1 *	ng was placed after			If the DON identifies	
	*	•			assessments not done per	
	· ·	eatment. The fistula			facility policy she will make sure that an assessment is	
	site on the insi	de of the resident's			done as soon as possible a	
	upper right arr	n was observed to			interventions for the reside	ı
	have pinhead-	sized scabbed areas			are updated and put into pl	
		dialysis needle			Once the assessment is	
		·			complete, the DON will add	ress
	insertion sites.				the issue with the staff	
	ļ				!	

li i			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155417	A. BUI	LDING	00	04/05/2011
		155417	B. WIN			04/03/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
HICKUD.	Y CREEK AT SCOT	TSRUPG	1100 N GARDNER AVE SCOTTSBURG, IN47170			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
1110	REGELITORI OR	ESC IDENTIFICATION CHARACTERS		1710	involved, including re-train	
	.	4/5/11			as necessary and progress	• I I
		ew on 4/5/11 at 2:40			disciplinary action for	
	p.m., the Direc	ctor of Nursing			continued noncompliance.	
	(DON) indicat	ed she could find no			DON or designee reviewing	the
	assessment of	the area on Resident			24 hour report and focus charting will complete the 0	₂₄
		clinical record or on			audit form F272 at least 5 d	
		heets in the Skin			per week and bring the resi	
					to the daily interdisciplinary	_
		naintained at the			team meeting for review. 4.	How_
	nurse's station.	. The DON indicated			will corrective action be monitored to ensure the	
the resident always returned from				deficient practice does not		
dialysis with a pressure dressing to				recur and what QA will be p	· I	
	*	and the dressing was			into place? The DON will be	
		after eight hours.			the results of the QA audits	<u>to</u>
		· ·			the interdisciplinary team	.
		cated on 3/21/11 the			meeting 5 days per week, the weekly Standards of Care	<u>ie</u>
	dialysis center	called the facility to			meeting, the monthly QA&A	\
	let the facility	know the resident's			Committee meeting and to	
	skin at the acc	ess site had a			quarterly QA&A Committee	_
	problem The	DON indicated the			meeting that is attended by	
	_	would get very upset			medical director for review recommendations. The QA	and
	_	• • •			audit-272 will be done 5 day	/sa
	_	eft the pressure			week for 30 days, then wee	
	_	e site. The DON			for the next 30 days. At tha	t
	indicated she r	remained at the			time, the audit tool will	
	facility until th	ne dressing was to be			continue at a frequency determined by the QA&A	
	•	21/11, so she would			Committee, and can be	
		e problem was. She			discontinued by the QA&A	
		n she looked at the			Committee when 100%	
					compliance is achieved. Th	is
	site she first "t				process and review of the 24-hour report and review of	,
	ringworm," bu	t when she looked			the focus charting 5 days p	l l
	closer, she real	lized there were tiny			week will continue on an	
		-				

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	ĺ	LDING	00	(X3) DATE SURVEY COMPLETED 04/05/2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	access site. The dialysis center documentation the skin proble indicated she of documentation assessment of 3/21/11, or that assessed again Treatment Recommond was her before the skin problem of the skin problem. Treatment Recommond was her before the same of the skin problem of the same of the problem of the same of	could find no a of further the wound on at the wound was until the note on the cord indicating the aled on 3/29/11. 's care plan, d 10/1/09, and most ed with a Goal and 5/2011, indicated a of "I go to dialysis 3 I have end stage The only elated to the resident's a site indicated, site for S/S [signs] of infection."			ongoing basis even when documented audits are no longer required by the QA Committee. Date of compliance: May 5, 2011. Addendum to F 272 a.) What system is in place ensure lack of skin assessment does not recult is the policy of this fact that residents receive at two (2) showers or tub be per week, with partial between showers. Each the resident has a shower full bath, the CNA fills of "Shower Day Skin Audi (form HC-N-37). If a CN discovers a skin issue of kind, it is documented a time on the audit form a reported to the charge minmediately. In addition to the above charge nurse performs weekly skin assessments all residents and document findings on the "Weekly Skin Assessment-HC-N-form (see attachments). These are placed with the focus charting for review the DON each morning part of her routine duties.	ace to ar? cility least baths aths time er or out a t" NA any t that and nurse , the son ents 38"

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:					ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155417	A. BUI B. WIN			04/05/2011
NAME OF I	DROVIDED OD CUIDDUIED		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER			1	GARDNER AVE	
HICKOR	Y CREEK AT SCOT	TSBURG		SCOTT	SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
-) fistula to the upper		-		
	right arm.	, 11			The Shower Day Skin Au	ıdit
	8				forms are given to the Do	ON
	During intervi	ew on 4/5/11 at 3:30			each day so that she may	
	_	uest for the facility's			review each one. In addition	tion,
		to dialysis fistula			the DON will review the	.
	1 2	provided a policy			focused charting and 24 report each morning as p	
		nt Care, Dialysis" and			of her tour of duty. This)ait
	·	•			allows her to follow up of	n
indicated the facility did not have a policy specific to care of a fistula				any identified issues at th		
				time to make sure that th	ie	
	access for dial	ysis.			necessary interventions l	nave
					been put into place. In	
		0:00 p.m., review of			addition, if she does not	
	the website				receive a skin audit form	on
	http://www.da	vita.com/kidney-dise			the day that a resident's shower/bath was schedul	bol
	ase/dialysis/tre	eatment/arteriovenous			or if a Weekly Skin	leu
	-(av)				Assessment has not been	
	-fistula-?-the-ខ្	gold-standard-hemodi			done or completed with	
	alysis-access/e	e/1301 included, but			accurate information, th	is
	was not limited	d to, the following			will indicate the need for	
	related to asses	ssment of the fistula			follow up with the indivi-	
	site: "The vib	ration of blood going			nurse or CNA. She will t	hen
	through your a	rm is called the			intervene as indicated in	
		ould check this			question #3.	
	several times a	day. If the 'thrill'			b.) Were other residents	with
		ps a blood clot may			other skin needs assessed	
		By immediately				
		r doctor or dialysis			All other residents' skin	has
		m the clot may be			been assessed since the	
	nearm care tea				survey and any identified	l

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		LDING	00	(X3) DATE SURVEY COMPLETED 04/05/2011
	PROVIDER OR SUPPLIER Y CREEK AT SCOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
IAG	quickly dissolved Using a stethorough your ear the so through your a called the 'bruin pitch and so your blood vestightening (called tightening becompletely." During intervirum, the MDS Coordinator in the record individualysis fistular routinely for sinfection or fo She indicated	ved or removed. scope, or even ar to the access, you ound of blood flowing access. This sound is it.' If the sound gains ounds like a whistle, ssels could be led stenosis). If the omes too severe, ald be cut off ew on 4/5/11 at 3:30 is (Minimum Data Set) indicated nothing on cated the resident's is site was assessed igns and symptoms of ir the thrill and bruit. the site would be ing care but not on a sine basis. g relates to		IAG	skin issues have been assessed, documented a treated. c.) Has the re-training a in-service been complete. Yes, inservicing was don April 19, 2011. d.) What was the content Inservicing content including assessing and monitoring dialysis shunt/fistula sit signs/symptoms of infect from the Gold Standard Hemodialysis Access-Date In addition to the above non-licensed nursing state have been re-inserviced the facility policy and procedure for completic the shower day skin aud and licensed nursing state have been re-inserviced the policy and procedure weekly skin assessments. All other residents' skin	nd/or ed? ne on t? uded, re and g the e for tion l aVita. on on of lits aff on re for s.
	3.1 - 31(a)				been assessed since the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED				
		155417	A. BUII B. WIN			04/05/20	011
	PROVIDER OR SUPPLIER Y CREEK AT SCOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0279 SS=D	resident's comprehence The facility must do care plan for each measurable object a resident's medic psychosocial needs comprehensive as The care plan mustare to be furnished resident's highest mental, and psych required under §48 would otherwise be but are not provide exercise of rights oright to refuse treat Based on obset review, and introduced to wour residents review care in a samp The facility also care was plant management of 1 of 1 residents.	evelop, review and revise the hensive plan of care. evelop a comprehensive resident that includes review and timetables to meet al, nursing, and mental and is that are identified in the sessment. It describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that is required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). Invation, record terview, the facility is care was planned and care for 1 of 4 and related to wound the of 9. (Resident F) is of failed to ensure	F0	279	F279 It is the policy of this facility to use the results of assessment to develop, revand revise the resident's comprehensive care plan the includes measureable objectives and timetables to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive care plan the includes measureable objectives and timetables to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive care plants in the care plants in	d ithe riew nat o e ssive re ssis	05/05/2011

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	V/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155417	B. WIN			04/05/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				GARDNER AVE	
HICKOR,	Y CREEK AT SCOT	TSBURG			SBURG, IN47170	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	TAG		DATE
					those residents found to ha	i <u>ve</u>
	Findings inclu	de:			been affected by the deficiency? Resident F care	
					plan has been updated to	<u>-</u>
	701 1· · 1	1.C. D. :1. 4.E.			include specific dialysis fis	tula
	The clinical re	cord for Resident F			site care and checking the	
	was reviewed	on 4/4/11 at 4:15			dialysis fistula site for bruit	. &
	p.m. The resid	dent's diagnoses			thrills every shift. The wour	
	^	•			that was at the dialysis fistu	
	[were not limited to,			site on the right upper forea	arm_
	end stage rena	l disease.			of Resident F has healed.	
					2.How will the facility identi	<u>fy</u>
	A. A physicia	n's order was			other residents having the	.
					potential to be affected by t	<u>he</u>
		21/11 and indicated,			same practice and what	
	"Apply Bacitra	acin [antibiotic			corrective action will be tak No other residents were	<u>enr</u>
	ointment] dail	y to blisters on LUE			affected by this practice. No	,
		remity]. Keep area			other resident(s) residing a	
					facility receive dialysis	<u></u>
	covered and cl	ean."			services. 3.What measures	will_
					be put into place to ensure	this
	Documentation	n on the clinical			practice does not recur? _ T	he
					licensed nurses including t	
		o indicate a plan			MDS Coordinator and Direc	· · ·
	related to the c	care of the area of the			of Nurses will be inserviced	l on
	upper arm requ	uiring treatment.			completing accurate	.
	^	_			assessments, as well as the frequency, method and	,
	The Treatment	Dagard for March			timeliness required to upda	te
		Record for March			care plans and intervention	
	2011 indicated	l an entry for "Apply			the resident assessment is	
	Bacitracin oint	tment to blisters on			complete. Care plans shall	
	RUE [sic] [rio	ht upper extremity].			continue to be initiated upo	n
		**			the admission/readmission	
	*	ered and clean."			each resident to the facility	,
	Documentation	n after the treatment			reviewed, and updated at	
	was completed	d on 3/29/11.			intervals throughout the	
	indicated, "He				resident's length of stay. O	
	marcaica, 116	arca.			completed, the resident will	i ne

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/05/2011
		100111	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1/00/2011
NAME OF I	PROVIDER OR SUPPLIEF	2		1	GARDNER AVE	
	Y CREEK AT SCOT				SBURG, IN47170	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	re-evaluated for appropriate	
	.				interventions. Care plans a	I
		ration of Resident F's			CNA assignment sheets wi	l l
	dialysis access	s site on $4/5/11$ at			updated as needed to matc	h
	1:25 p.m., the	MDS (Minimum			the assessed status of the	
	Data Set) Coo	rdinator was			resident. At least 5 days a week, the DON will review t	he
	ĺ	She and indicated			24 hour report, focus chart	l l
		ad a dialysis shunt to			and any other associated	
					documentation to identify a	-
		t arm and attended			resident who has had a cha in condition or functional	inge
		times a week on			capacity, including a woun	d or
	Monday, Wed	nesday, and Friday.			other skin issues. She will	
	The MDS Coo	ordinator indicated the			make sure that an assessm	
	resident had w	hat the nurse thought			is done and followed through	gh
	was a tape but	n to the area where			in the care plan and CNA assignment sheets, if	
	1	essing was placed			indicated. Once the	
	l	sis treatment. The			assessment and care plan	is
	1				complete, the DON will add	ress
		ator indicated her			the issue with the staff involved, including re-train	ina
	l	was the four corners			as necessary and progress	_
	of the taped ar	ea a dressing was			disciplinary action for	
	covering had l	been visible on the			continued noncompliance.	
	resident's skin	. The fistula site on			DON or designee reviewing	the
	the inside of the	he resident's upper			24 hour report and focus charting will complete the 0	DA
		observed to have			audit form F279 at least 5 d	
	~	scabbed areas in a			per week and bring the res	
	^				to the interdisciplinary tear	_
		ysis needle insertion			meting at the next schedule morning management mee	
	sites.				that is held at least 5 days	
					week. In addition, any resid	
	During intervi	ew on 4/5/11 at 2:20			changes will be discussed	
	p.m., the Dire	ctor of Nursing			weekly at the Standards of Care meeting. These proce	l l
	· ·	ted she would expect			and reviews will continue o	I

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155417		A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/05/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	related to the orequired the trequired the trequired the trespondent of the control of the contr	ew on 4/5/11 at 2:40 etor of Nursing red she could find no red to the area on rm in the clinical re binder for the s Notes, maintained station.			ongoing basis. 4.How will corrective action be monito to ensure the deficient prace does not recur and what Q. will be put into place? The will bring the results of the audits to the interdisciplinate team meeting 5 days per with the weekly Standards of Cameeting, the monthly QA&. Committee meeting and to quarterly QA&A Committee meeting that is attended by medical director for review recommendations. The QA audit-279 will be done 5 daweek for 30 days, then week for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. The process and review of the 24-hour report and review of the focus charting 5 days power will continue on an ongoing basis even when documented audits are no longer required by the QA&C Committee. Date of compliance: May 5, 2011. Addendum to F 279 Were other residents care plans reviewed? Yes. All other residents identificated as having skin issues or woundaye had their care plans reviewed.	Ctice A DON QA Ary eek, are A the and ys a kly t t fied ds

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/05/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	other care was the access site A Hemodialys 6/28/10, from previous dialy indicated the r (arteriovenous right arm. During intervi p.m., upon req policy related care, the DON entitled, "Shur indicated the f policy specific access for dial On 4/5/11 at 1 the website http://www.da ase/dialysis/tre-(av) -fistula-?-the-galysis-access/ea	is Flow Sheet, dated the resident's sis provider, esident had an AV) fistula to the upper ew on 4/5/11 at 3:30 uest for the facility's to dialysis fistula provided a policy at Care, Dialysis" and facility did not have a set to care of a fistula			and updated as needed. The I will check for completion of a newly identified skin issues as of her review of the focus characteristics of her review of the focus characteristics and weekly skin assessment sheets. If she finds any issues, she will follow up as indicated in the profession of correction #3.	ny part rting, cin		

NAMI-OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG (PACH DEFICIENCY MIST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATIONS related to care of the fistula site: "Any restriction of blood flow can cause clotting. Here are some tips to help keep blood flowing without restriction: Avoid tight clothing or jewelry that could put pressure on your access area; don't let anyone put a blood pressure taken from your non-access arm.; request that blood being drawn is taken from your non-access arm; don't sleep with your access arm under your head or pillow; check the pulse in your access daily. The vibration of blood going through your arm is called the 'thrill.' You should check this several times a day. If the 'thrill' changes or stops a blood clot may have formed. By immediately contacting your doctor or dialysis health care team the clot may be quickly dissolved or removed. Using a stethoscope, or even		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
HICKORY CREEK AT SCOTTSBURG (X4)ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MLST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) related to care of the fistula site: "Any restriction of blood flow can cause clotting. Here are some tips to help keep blood flowing without restriction: Avoid tight clothing or jewelry that could put pressure on your access area; do not carry bags, purses or any type of heavy item over your access arm - have your blood pressure taken from your non-access arm; request that blood being drawn is taken from your non-access arm; don't sleep with your access arm under your head or pillow; check the pulse in your access daily. The vibration of blood going through your arm is called the 'thrill.' You should check this several times a day. If the 'thrill' changes or stops a blood clot may have formed. By immediately contacting your doctor or dialysis health care team the clot may be quickly dissolved or removed. Using a stethoscope, or even			155417				04/05/2	2011	
HICKORY CREEK AT SCOTTSBURG (X3.10) SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) related to care of the fistula site: "Any restriction of blood flow can cause clotting. Here are some tips to help keep blood flowing without restriction: Avoid tight clothing or jewelry that could put pressure on your access area; do not carry bags, purses or any type of heavy item over your access area; don't let anyone put a blood pressure taken from your non-access arm; request that blood being drawn is taken from your non-access arm; don't sleep with your access arm under your head or pillow; check the pulse in your access daily. The vibration of blood going through your arm is called the 'thrill' You should check this several times a day. If the 'thrill' changes or stops a blood clot may have formed. By immediately contacting your doctor or dialysis health care team the clot may be quickly dissolved or removed. Using a stethoscope, or even	NAME OF I	PROVIDER OR SUPPLIER		<u>'</u>	1				
SUMMARY STATEMENT OF DEFICIENCIES TAG	HICKOR)	Y CREEK AT SCOT	TSBURG		1				
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quickly dissolved or removed. Using a stethoscope, or even			•						
Using a stethoscope, or even			·						
I mutting your oar to the econg you		_	-						
putting your ear to the access, you			· · · · · · · · · · · · · · · · · · ·						
can hear the sound of blood flowing		can hear the so	ound of blood flowing						

I '		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155417	B. WIN	G		04/05/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	-	
חוכאטםי	Y CREEK AT SCOT	TODLIDG			GARDNER AVE SBURG, IN47170		
					SBURG, IN47 170		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		access. This sound is					
	• •	it.' If the sound gains					
		•					
	in pitch and sounds like a whistle, your blood vessels could be						
		led stenosis). If the					
		omes too severe,					
	blood flow cou	ald be cut off					
	completely."						
	This federal ta	g relates to					
	Complaint IN(00088379 and					
	IN00088699.						
	3.1-35(b)(1)						
	3.1-35(d)(2)(b)					
	3.1 33(u)(2)(0)					
F0282		ded or arranged by the					
SS=D		ovided by qualified persons					
	in accordance with plan of care.	n each resident's written					
	= -	rvation, record	F0	282	F282 It is the policy of this	ľ	05/05/2011
		terview, the facility			facility that services provide		
		e physician's orders			or arranged by the facility n	nust_	
		for dressing changes			persons in accordance with	<u>. </u>	
		0 0			each resident's written plan		
	to a gastrostomy tube site for 1 of 4 residents reviewed related to physician's orders for wound care in a sample of 9 residents. (Resident				care including administration		
					of treatments as ordered by physician. 1.What corrective		
					action will be accomplished		
					those residents found to ha	<u>ive</u>	
	B)				been affected by the	<u>,</u>	
					deficiency? The nurse(s) the worked the night of April 2nd		
					and April 3rd have received		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CON	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155417	B. WIN			04/05/2011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
				1	GARDNER AVE	
	Y CREEK AT SCOT	12R0KG		SCOTTS	SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	Findings inclu	de:			disciplinary action for failu follow physician orders for	
					dressing change. The licen	
	During observa	ation with the			nurses and QMA will be	_
	Director of Nursing (DON) on				inserviced on following	
		p.m., Resident B's			physician orders for	
	l '	-			medication & treatments	, to
	I -	be dressing was			including dressing changes a gastrostomy tube site, the	
	observed with	the date of $4/1$			five (5) R's of medication	<u> </u>
	followed by a	nurse's initials.			administration, and the	
	During intervi	ew at this time, the			expectation that physician	
		d the dressing was			orders will be followed as	
		· ·			given. 2.How will the facility	
		1/11 by (name of			identify other residents have the potential to be affected	
	nurse). The D	ON indicated the			the same practice and wha	
	dressing and g	astrostomy stoma site			corrective action will be tal	_ '
	were clean. O	bservation indicated			No other residents have be	<u>een</u>
		as not soiled, and the			found to be affected. The	
	_				Director of Nurses or desig	l l
	_	crusting and slightly			will perform random dressi change checks 5 days per	ng
	reddened skin	surrounding.			week for 30 days, then 3 ti	mes
					per week for 30 days to ens	l l
	The clinical re	cord for Resident B			dressings and treatments a	l l
	was reviewed	on 4/4/11 at 1:00			done per physician orders.	l l
		OII 1/ 1/ 11 W. 1.00			any treatment or dressing i	
	p.m.				noted not done as ordered	·
					the attending physician the treatment shall immediately	l l
	Physician's ord	ders for April 2011			done as ordered and the	
	indicated an or	der for "Cleanse			attending physician and leg	gal
	G-tube [gastro	stomy tube] site			representative shall be not	
		for with] warm H2O			Once the resident's needs	
		=			been taken care of, the Dire of Nurse's will address the	ector
		o, pat dry, & apply			identified issue(s) with the	
	drain sponge."				involved staff, including	
					re-training as necessary an	d
FORM CMS-2	2567(02-99) Previous Versio	ns Obsolete Event ID: {	L 880W11	Facility II	D: 000421 If continuation s	heet Page 17 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155417	B. WIN			04/05/2011
			D. ,, 11.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG			SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT	DATE
1710			 	mo	progressive disciplinary ac	
		t Record for $4/1$, $4/2$,			for continued noncomplian	
	4/3, and $4/4/11$ indicated the				The DON or designee	
	dressing had been changed as				reviewing the 24 hour repor	<u>t</u>
	ordered on the 10:00 p.m. to 6:00				and focus charting will	
	a.m. shift.	10.00 p.m. 00 0.00			complete the QA audit form	
	a.111. S1111t.				F282 at least 5 days per we	
					and bring the results to the	-
	Nurse's Notes	for 4/1/11 at 12:00			interdisciplinary team meting the next scheduled morning	
	a.m. and 4/2/1	1 at 1:00 a.m.			management meeting that i	
	indicated the s	toma was cleansed as			held at least 5 days per wee	
					In addition, any resident	
		note for 4/1/11 also			changes will be discussed	
	indicated a dra	in sponge was			weekly at the Standards of	
	applied.				Care meeting. These proces	I
	**				and reviews will continue o ongoing basis. 3.What	n an
	During intervi	ew on 4/5/11 at 2:20			measures will be put into p	lace
	_				to ensure this practice does	
	_	I indicated she did not			not recur? As stated above	
	re-check the in	nitials on the dressing			Director of Nurses or desig	I
	dated 4/1/11.	She indicated the			will perform random dressi	ng
	nurses on the s	subsequent dates had			change checks 5 days per	
		-			week for 30 days , then 3 tir per week for 30 days to ens	I
		essing was changed.			dressings and treatments a	
		she had no reason to			done per physician orders.	
	think the dress	sing had not been			any treatment or dressing is	I
	changed by the	e nurse as indicated			noted not done as ordered	- 1
	, ,	ent Record, and she			the attending physician the	I
		<i>'</i>			treatment shall immediately	[/] be
		e date of 4/1 on the			done as ordered and the attending physician and leg	ıal
	dressing was j	ust mis-dated.			representative shall be noti	
					Once the resident's needs h	I
	This federal ta	g relates to			been taken care of, the Dire	
	Complaint IN(•			of Nurse's will address the	
		JUU00 <i>3 3</i> .			identified issue(s) with the	
					involved staff, including	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155417		(X2) MU A. BUII B. WING	LDING	00	(X3) DATE: COMPL 04/05/2	ETED	
	PROVIDER OR SUPPLIER Y CREEK AT SCOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	3.1-35(g)(2)				re-training as necessary an progressive disciplinary act for continued noncompliant. The DON or designee reviewing the 24 hour repo and focus charting will complete the QA audit form F282 at least 5 days per we and bring the results to the interdisciplinary team metit the next scheduled morning management meeting that held at least 5 days per we lin addition, any resident changes will be discussed weekly at the Standards of Care meeting. These proce and reviews will continue of ongoing basis. 4.How will corrective action be monitor to ensure the deficient pracedoes not recur and what Quwill be put into place? The will bring the results of the audits to the interdisciplinate team meeting 5 days per we the weekly Standards of Cameeting, the monthly QA&A Committee meeting and to quarterly QA&A Committee meeting and to quarterly QA&A Committee meeting that is attended by medical director for review recommendations. The QA audit-282 will be done 5 day week for 30 days, then week for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be	tion ce. rt lek log at gisek. sses on an ored orice A DON QA ary eek, are A the and ys a kly	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155417		A. BUII	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/05/2011		
	PROVIDER OR SUPPLIER		B. WING 0470372011 STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
					discontinued by the QA&A Committee when 100% compliance is achieved. The process and review of the 24-hour report and review of the focus charting 5 days poweek will continue on an ongoing basis even when documented audits are no longer required by the QA& Committee. Date of compliance: May 5, 2011. Addendum to F 282 a.) Has the in-service for Nurses and QMAs been completed? Yes. The inservice was conducted 4-28-2011 and ongoing. b.) What was the content. The content included the facility policy and proced for physician orders, physician order-monthly recap, change in condition focus charting, expectation and 5 Rs of medication administration. c.) What process was completed to determine no other residents were affect During the survey the Director of Nurses check every treatment to ensur	of oer AA the con, ons oeted?	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155417		A. BUILDING 00 COM			(X3) DATE S COMPL 04/05/2	ETED	
		100417	B. WIN			04/03/2	011
NAME OF P	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE		
HICKOR	Y CREEK AT SCOT	TSBURG	SCOTTSBURG, IN47170				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
					had been done and was		
					dated and initialed by the		
					nurse that completed the		
					treatment. No other resid		
					were identified as having		
					out-dated treatments.		
F0312 SS=D	of daily living recei to maintain good n personal and oral l		E0	312	F312 It is the policy of this		05/05/2011
		rvation, record	FU	312	facility that a resident who	ie	03/03/2011
	review, and int	terview, the facility			unable to carry out activitie		
	failed to provide	de for the personal			daily living receives the	<u> </u>	
	*	esidents who were			necessary services to main	tain_	
					good nutrition, grooming, a	ınd_	
	•	care in activities of		personal and oral hygiene.			
		r 3 of 5 residents			1.What corrective action wi accomplished for those	II be	
	reviewed relate	ed to hygiene and			residents found to have been	en en	
	grooming in a	sample of 9			affected by the deficiency?		
	_	sidents B, C, and J)			Residents that are unable to		
	residents. (100)	sidents B, C, and s)			carry out activities of living	<u>L</u>	
	TO: 1: 1	•			independently shall receive		
	Findings inclu	de:			grooming and personal and	_	
					oral hygiene care by facility CNAs as needed. Resident'		
	1. During Init	ial Tour of the facility			shall receive shaves as nec		
	_	:30 a.m., Resident C			or ordered. The facility has		
		seated in his wheel			"guardian angel program",		
					which each department		
		llway. The resident			manager is assigned a grou	<u>ap</u>	
	was unshaven	and had bits of skin			of residents to monitor to ensure residents receive th	_	
	and debris arou	und the lips and			necessary services to main		
	mouth. The resident was observed in the dining room awaiting lunch				good nutrition, grooming, a		
					personal and oral hygiene.	_	
	_	•			2.How will the facility ident	ify	
	service on 4/4/	'11 at 12:15 p.m. The			other residents having the		

j		(X2) M	ULTIPLE CO	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155417	B. WIN	G		04/05/2011		
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				1100 N GARDNER AVE				
HICKOR	Y CREEK AT SCOT	TSBURG		SCOTT	SBURG, IN47170			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T			
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE .		
	resident remain	ned unshaven and the			potential to be affected by t same practice and what	<u>:ne</u>		
	bits of skin and debris remained				corrective action will be take	en?		
	about the mou	th. When lunch was			The Director of Nurses or			
	served the res	ident was observed			designee, charge nurse's a	<u>nd</u>		
	ŕ				department managers shall	<u> </u>		
		lf with built-up			make frequent rounds and	_		
	utensils.				monitor residents regularly			
					ensure residents are shave free from dirty faces, in	<u>n,</u>		
	On 4/5/11 at 1	0:05 a.m., Resident C			clothing that is not soiled o	r		
		in his room in bed			stained and receive person	_		
					and oral hygiene as needed			
	_	closed. The front of			3.What measures will be pu	<u>ıt</u>		
	the resident's u	indershirt was stained			into place to ensure this			
	with yellow ra	diating out from the			practice does not recur? The Director of Nurse's or design			
	neck area dow	n the chest.			will conduct random check			
					three (3) residents per day			
	On 4/5/11 at 1	2:55 n m Pagidant C			varying shifts 5 days per w			
		2:55 p.m., Resident C			for 30 days, then 3 times pe	er		
		in his wheel chair in			week for 30 days to ensure			
	the hallway ou	itside his room. The			residents that are unable to carry out activities of daily	'		
	resident's unde	ershirt was stained			living receive the necessary	,		
	with the same	yellow stain radiating			services to maintain good	'		
		eck area down the			nutrition, grooming, and			
					personal and oral hygiene I			
		food debris were			addition to the random che	1		
	observed on th	e shirt also.			done by the Director of Nur or designee, as part of the	ses		
					facility "guardian angel			
	Review of the	CNA Assignment,			program" the departments			
		CNA #10 on 4/4/11			managers shall make frequ			
	at 12:15 p.m., indicated Resident C				rounds and monitor care ar	l l		
	_				services to the residents. If	· ·		
	required incon				manager(s) identify a resident that is unable to carry out	ent		
	maximum assi	stance for bathing,			activities of daily living and	is		
	was transferred	d by lift, and heels			in need of care it shall be			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THEFTERN	or connection	155417	A. BUI			04/05/2011
		100111	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1/00/2011
NAME OF F	PROVIDER OR SUPPLIER				GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG			SBURG, IN47170	
				ID		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	were floated in	bed. Special			reported to the charge nurs	se
		the "Instructions"			and director of Nurse's	_
	column included, but were not				immediately. The Director of Nurses will ensure the resident	1
	ŕ				is taken care of at once. Or	
	· ·	Must be shaved			the resident's needs have t	· ·
	daily"				taken care of, the Director	of
					Nurse's will address the	
	2. During obs	ervation on the Initial			identified issue(s) with the	
	Tour on 4/4/11				involved staff, including re-training as necessary an	ud
		s observed in bed.			progressive disciplinary ac	
	Resident D wa	s observed in bed.			for continued noncomplian	
					The DON or designee will	
	During observa	ation in the dining			document the random ched	
	room on 4/4/11	1 at 12:15 p.m.,			using QA audit form -312 a bring the results to the	<u>nd</u>
	Resident B wa	s seated in a slightly			interdisciplinary team meti	ng at
		backed wheelchair.			the next scheduled mornin	
		meal had not been			management meeting that	
					held at least 5 days per wed	
		y, thick yellow debris			Department manager "guar angel program" rounds sha	
	was observed of	on the lips and sides			be documented on the	<u>all</u>
	of the resident	's face and down the			"guardian angel program"	form
	chin. Thick str	rings of yellow			and the results shall be	
		e clinging to and			reviewed by the	
		ween the resident's			interdisciplinary team at the	<u>e</u>
					next scheduled morning management meeting that	is
		lips. Before staff			held at least 5 days per wee	
	_	the resident, she was			In addition, any resident	_
	observed using	g the right hand to rub			changes will be discussed	
	at the debris or	n the lips and around			weekly at the Standards of	
	the mouth.				Care meeting. These proce and reviews will continue of	
					ongoing basis. 4.How will	
	Daview of the	CNA Accionment for			corrective action be monitor	ored_
		CNA Assignment for			to ensure the deficient prac	
	Kesident B ind	licated two asterisks			does not recur and what Q	<u> </u>

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155417		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/05/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) MPLETION DATE
	"Bath Instruction two asterisks as shift and property in the concernment of the concernme	ervation in the dining 1 at 12:15 p.m., s seated at the table 1. The resident's lips 1 to have a heavy 1 f debris. The tongue 1 dhad a heavy yellow 1 ew on 4/5/11 at 2:20 erns related to care of 1 c., and J were 1 the Director of 1 lb. The DON nodded. providing care for 1 s a challenge. It is greates to 100088379 and 1 lb.			will be put into place? The will bring the results of the audits to the interdisciplinateam meeting 5 days per with weekly Standards of Cameeting, the monthly QA&. Committee meeting and to quarterly QA&A Committee meeting that is attended by medical director for review recommendations. The QA audit-312 will be done 5 day week for 30 days, then weefor the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. The process and review of the 24-hour report and review of the 24-hour report and review of the focus charting 5 days give week will continue on an ongoing basis even when documented audits are no longer required by the QA&Committee. Date of compliance: May 5, 2011. Addendum to F 312 a.) What actions were taken for Resident C, Resident B and Resident J? Resident C-Dithe survey the Director of Nurses instructed the CNA change the resident C's clothing and also to shave resident immediately. Resident of Nurses instructor of Nurses instructor of Nurses B-Once the Director of Nurses B-Once the Direct	QA ITY eek, ITE A the and ys a kly tt is of eer A the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	A. BUIL	DING	00 	COMPL 04/05/2	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					was made aware that the resident needed oral care instructed the CNA to provioral care to the resident immediately. Resident J 0 the Director of Nurses was made aware that the reside needed oral care she instruthe CNA to provide oral care the resident immediately. Were other residents assess for care needs? Yes. All oth residents were assessed for care needs and care was provides as needed. The Director of Nurses made suthat all identified residents needing care had their care needs met appropriately by staff. Once that was done, so followed up with staff as indicated in #3 of F312 on the POC. c.) Was staff in-service and/or re-education provided Yes. The facility policy and procedure for oral hygiene denture care with post test conducted 4/28/2011 and ongoing. d.) What was the content of the program? On hygiene and denture care inservicing included the purpose of oral hygiene/denture care and the during the day when oral hygiene shall be rendered.	or and was	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

880W11 Facility ID:

000421

If continuation sheet

Page 25 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155417		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURV COMPLETE 04/05/2011			LETED		
		199417	B. WIN			04/05/2	.011
	PROVIDER OR SUPPLIER Y CREEK AT SCOT			1100 N	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170		
					3BUNG, IN47 170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
		,	+	TAG	BLI ICILACT)		DATE
F0328 SS=D	proper treatment a special services: Injections; Parenteral and ent Colostomy, uretero Tracheostomy care; Tracheal suctioning Respiratory care; Foot care; and Prostheses. Based on obset and record reverse failed to ensure tanks were filled and functioning for providing of the special services.	ostomy, or ileostomy care; e;	F0	328	F328 It is the policy of this facility to ensure that reside receive proper treatment ar care for special services. 1.What corrective action wi accomplished for those residents found to have been affected by the deficiency? Both licensed and unlicens nursing staff has been	ll be	05/05/2011
	deficient pract	ice affected 3 of 4			inserviced on how to check when to check and when to		
					portable oxygen tanks. 2.Ho		
		sample of 9 residents.			will the facility identify other		
	(Residents C, 1	D, and F)			residents having the potent to be affected by the same	<u>iiai</u>	
	Findings inclu	de:			practice and what corrective action will be taken? All residents with physician or		
	1. During Init	ial Tour of the facility			for oxygen use have the potential to be affected by t	hic	
	U	:30 a.m., Resident C			practice. As stated previous		
		seated in his wheel			both licensed and unlicense		
					nursing staff have been		
	chair in the hal	•			inserviced on how to check		
	resident's whee	el chair was a			when to check and when to		
	portable oxyge	en tank with tubing to			portable oxygen tanks. 3.W		
		a to the resident's			measures will be put into po		
	a nasar camran	a to the redicent b			not recur? The Director of	<u>. </u>	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155417			LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER Y CREEK AT SCOT		•	1100 N (ddress, city, state, zip code GARDNER AVE SBURG, IN47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	the MDS (Mir Coordinator was level of oxygem MDS Coordinator was made and the tank. The observed to probe tween the resume of the incomposition of the incom	ed zone and the green dicator knob. The ator indicated the ost empty," removed the resident's wheel tit for refill. ecord for Resident C on 4/4/11 at 4:20 sician's orders for eluded, but were not 2 [oxygen] @ 2L/NC minute by nasal			Nurse's or designee will conduct random checks or three (3) residents per day varying shifts 5 days per w for 30 days, then 3 times p week for 30 days to ensure resident that have orders oxygen have oxygen tanks have been filled and that so know when and how to fill oxygen tanks. If the Director Nurse's or designee find oxygen tanks that are emp staff do not know when and how to fill oxygen tanks, the Director of Nurse's or designee the resident's needs. Once resident's needs have been taken care of, the Director Nurse's will address the identified issue(s) with the involved staff, including re-training as necessary ar progressive disciplinary action for continued noncompliar The DON or designee reviewing the 24 hour reposand focus charting will complete the QA audit form F328 at least 5 days per we and bring the results to the interdisciplinary team mee at the next scheduled morn management meeting that held at least 5 days per we ln addition, any resident changes will be discussed weekly at the Standards of Care meeting. These processive the standards of Care meeting.	on reek er for that taff or of the ngnee of the n of reek ting ning is ek.	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	
		155417	B. WIN			04/05/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE	
HICKOR	Y CREEK AT SCOT	TSBURG			SBURG, IN47170	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
tilted the tank and indicated the					and reviews will continue o	n an
	tank was empty and stated, "I'll go				ongoing basis. 4.How will corrective action be monited	arod
	_	for you." After CNA			to ensure the deficient prac	
	_	•			does not recur and what Q	
		ng room to fill the			will be put into place? The	
		tor of Nursing came			will bring the results of the	
	into the dining	room, and during			audits to the interdisciplina	
	interview at th	is time, indicated			team meeting 5 days per we the weekly Standards of Ca	
	CNA #7 did no	ot know how to read			meeting, the monthly QA&A	
	the oxygen tan	k properly and that			Committee meeting and to	
the oxygen tank properly and that				quarterly QA&A Committee	_	
Resident F's portable oxygen tank				meeting that is attended by		
	was actually about one-third full.				medical director for review	
	She indicated t	the aide was going to			recommendations. The QA audit-328 will be done 5 day	ı
	fill it now.				week for 30 days, then wee	
					for the next 30 days. At tha	-
	The clinical re	cord for Resident F			time, the audit tool will	
		on 4/4/11 at 4:15		continue at a frequency		
					determined by the QA&A Committee, and can be	
		's orders for April			discontinued by the QA&A	
	2011 included,	but were not limited			Committee when 100%	
	to, "O2 @ 2L/.	NC continuously."			compliance is achieved. Th	is
					process and review of the	
	3 During obs	ervation in the dining			24-hour report and review of the focus charting 5 days p	ı
		1 at 12:15 p.m., the			week will continue on an	
		•			ongoing basis even when	
		ed for the setting and			documented audits are no	
		vel of oxygen in the			longer required by the QA8	A
	portable tank of	on the back of the			Committee. <u>Date of</u> compliance: May 6, 2011.	
	wheel chair of	Resident D, which			Addendum to F 328	
	was connected	to the tubing to the			a.) What actions were tak	en
		l cannula. The DON			for Resident C, Resident I	
		ank was set on "three			and Resident F?	
		ank was set on three				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED			(X3) DATE SURVEY
THETETAL	or connection	155417				04/05/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG		SCOTT	SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		en per minute]." She			Residents C, D and F	5.112
	lifted and tilted	• •			physician orders for oxy	gen
	indicated the ta				have been reviewed. CNA	\
		y contents. She			assignment sheets and ca	
	-	ibing from the tank			plans have been reviewed	
		the whistling through			and updated as needed to	
		ng told her there was			identify residents that ha orders for oxygen therap	
	_	tank. She indicated			what those orders are an	·
					is listed on the treatment	1
	she would replace the resident's tank and notify the respiratory				administration record	
					(TAR).	
		e problem. She				
		espiratory company			Every shift the licensed	
	visits once a w	eek.			nurse shall check the lite	r
					flow, assess resident's respirations and blood	
		cord for Resident D			oxygen saturation and	
		on 4/4/11 at 2:00			document it on the treati	nent
		n's orders received at			administration sheet (TA	
		mission on 3/19/11			·	
	included, but v	were not limited to,			In addition to the above	
	"O2 at 3L/min	[minute] via N/C			every resident receiving	
	continuously."				oxygen therapy	
					shall have their portable	om 40
	During observ	ation in Resident D's			oxygen tank checked pri- each use. If its contents a	
	room on 4/5/1	1 at 11:00 a.m. with			full or less the tank shall	1
	the MDS Coor	dinator, she looked			filled prior to being used	1
	at the resident'	s portable oxygen				
	tank on the bac	ck of the resident's			b.) Was re-education and	
	wheel chair an	d indicated the			in-service provided to stay	·
	resident's porta	able tank was set at			Yes. Inservicing began or	1
	- Join Doin				April 13, 2011.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
12.12112111		155417	1	LDING		04/05/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1	GARDNER AVE	
HICKOR	Y CREEK AT SCOT	TSBURG		1	SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG		ninute. She indicated		IAG		DAIL
	a physician's o				c.) What was the content	of
		rate the resident's			the program?	
					Nursing staff were	
		with the goal of the			in-serviced on accurately	7
		rning home without			reading the gauges on the	
		en therapy. The			oxygen tanks, filling oxyg	·
		ator indicated the			tanks, including when an	
	CNAs were re	sponsible for			how to fill portable tanks	S.
	switching residents from the concentrator to the portable tank				Return demonstration	
					performed by nursing sta to assure that they learne	I
	when needed.				the information and are	
					to perform as expected.	abic
	The facility's r	policies related to			to periorm as expected.	
		en therapy tanks were			d.) Were all residents wit	h l
	1 30	te DON on 4/5/11 at			the need and/or the	
	_				physician's order for oxy	gen
		eview of "Filling of			assessed?	
	-	es" indicated, "11.			Yes. All residents who ha	ve
	•	id oxygen contents			current orders for oxyge	n
		sure the portable is			are assessed every shift.	
	filled to the gr	een full area"				
	Review of "Co	ompanion Portable			The licensed nurse	
	Units" indicate	ed, "Contents			checks the liter flow, asse	I
	Indicator: loca	ted on top of the			the resident's respiration and blood oxygen satura	I
		e pointer indicates			and documents it on the	uon
		how much oxygen			treatment administration	,
	remains in the	· ·			sheet (TAR) each shift.	
	131101110 111 0110				, , , , , , , , , , , , , , , , , , ,	
	This federal ta	g relates to				
	Complaint IN(-				
		JUU003/7.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	A. BUILDING B. WING	00	COMP 04/05/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	3.1-47(a)(6)							

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION 00	(X3) DATE S	ETED
		155417	B. WING			04/05/2	011
	PROVIDER OR SUPPLIER Y CREEK AT SCOT			1100 N (ddress, city, state, zip code GARDNER AVE SBURG, IN47170		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	1 '	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	ΓAG	DEFICIENCY)		DATE
F0441 SS=D	Infection Control P a safe, sanitary an and to help preven transmission of dis (a) Infection Control The facility must exprogram under who (1) Investigates, confections in the faction of the faction o	stablish an Infection Control nich it - ontrols, and prevents cility; orocedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted					
	transport linens so infection.	as to prevent the spread of					
		rvation, record	F044	1 1	F441 It is the policy of this		05/05/2011
		terview, the facility			facility to establish and	.	
	failed to ensure	,			maintain an Infection Contre Program designed to provide	_	
			1		safe, sanitary and comforta		
	handwashing a	ing gioving			environment and to help		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			On COMPL			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155417	A. BUI	LDING		04/05/2011
		155417	B. WIN			04/03/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE	
HICKOR)	Y CREEK AT SCOT	TSBURG		1	SBURG, IN47170	
					000100, 11171770	(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	techniques des	cribed in facility			prevent the development as	
policy and procedure when				transmission of disease an infection including the	<u>d</u>	
	providing inco	entinence care to 3 of			appropriate use of gloves a	<u>nd</u>
	3 residents obs				hand washing. 1.What	
		are in a sample of 9			corrective action will be	
		sidents B, C, and H)			accomplished for those residents found to have be	an
	residents. (Re	sidents B, C, and 11)			affected by the deficiency?	
	77. 1	1			Director of Nurse's will	_
	Findings inclu	de:			inservice nursing staff on	
					infection control including, incontinence care, proper	-
1. During observation of care on				glove use, and the procedu	res	
	4/4/11 at 1:30 p.m., CNA #10 and CNA #2 were observed providing				for hand washing and for u	
					of alcohol-based hand rub.	_
		re to Resident C.			2.How will the facility identi other residents having the	fy
		gloves to empty the			potential to be affected by t	he
					same practice and what	_
		noved her gloves, and			corrective action will be take	
		ng her hands or using			All residents have the poter	
	ĺ	she donned clean			to be affected by this practi As stated above, the Direct	
	gloves. CNA	#10 was also wearing			Nurse's will inservice nursi	
	gloves. The C	NAs assisted the			staff on the facility policy for	
	resident to star	nd using the stand-up			infection control including,	- I
		he perineal area and			incontinence care and hand washing/alcohol-based han	- 1
	soft stool from	•			rub. If any staff is observed	
		ving her gloves and			to follow the facility policies	
					and procedures in regards	
	_	ands or using hand			wearing and removal of glo with appropriate use of	<u>ves</u>
	· ·	x #2 rummaged in the			handwashing or alcohol ba	sed_
		ident C's night stand			hand rub, the DON will stop	the
	and indicated t	to CNA #10 to			staff person at that time, ha	
	remind her to g	get barrier cream for			him/her remove gloves and wash hands or use the alco	
	the resident. T	The resident was			based hand rub before	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155417	A. BUI	LDING	00	COMPLETED 04/05/2011
		155417	B. WIN			04/05/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
HICKOD,	Y CREEK AT SCOT	TODLIDO		1	GARDNER AVE SBURG, IN47170	
					360RG, IN47 170	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
		the bed and the bed	+		returning to resident care.	Bille
					Once the resident is taken	care_
		ed. Both CNAs			of, the DON will inservice th	<u>ne</u>
		gloves. CNA #2 left			staff involve on the facility	
	the resident's r	oom without washing			policy and procedure for appropriate glove use and	
	her hands or us	sing hand sanitizer.			handwashing. She will also	
		ained to clean the			render progressive discipli	- I
	resident's whee				for continued noncomplian	ce.
	resident's where	or chair.			3.What measures will be pu	<u>ıt</u>
	2. D 1	· · · · · · · · · · · · · · · · · · ·			into place to ensure this practice does not recur? T	he
		ervation of care on			Director of Nurses or desig	
4/4/11 at 3:30 p.m., CNA #3 and				will perform random	<u> </u>	
	CNA #8 were	observed providing			incontinence observations,	- I
	incontinent car	re to Resident B.			including hand-washing aft	
	Both CNAs we	ere wearing gloves.			the removal of gloves on two (2) residents 5 day per week	
		ted to remove the			30 days, then 3 times per w	
		A #3 cleansed the			for 30 days to ensure	
	· ·				incontinence care is perfor	
	resident's perir				in a safe and sanitary mann that prevents the developm	
		from the anal area.			and transmission of infection	
	_	ging gloves, CNA #3			and disease. If any staff is	
	obtained a tube	e of barrier cream and			observed not to follow the	
	applied the cre	eam to the resident's			facility policies and proced in regards to wearing and	<u>ures</u>
	cleansed anal a	area. CNA #3 then			removal of gloves with	
	removed her g	loves, washed her			appropriate use of	
	·	ned clean gloves.			handwashing or alcohol ba	
	· ·	IAs were rolling the			hand rub, the DON will stop staff person at that time, ha	
					him/her remove gloves and	
		side to side, CNA #10			wash hands or use the alco	- 1
		oved a draw sheet			based hand rub before	
	containing sme	ears of stool and			returning to resident care.	
	placed sheet in	a bag with soiled			Once the resident is taken of, the DON will inservice the	
	linens. CNA #	‡10 did not remove			staff involve on the facility	<u> </u>

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ((X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED		
		155417	B. WIN			04/05/2011		
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			1100 N	GARDNER AVE			
HICKOR	Y CREEK AT SCOT	TSBURG		SCOTT	SBURG, IN47170			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	•	wash her hands or			policy and procedure for			
	use hand sanit	izer. The CNAs			appropriate glove use and handwashing. She will also	,		
	proceeded to t	ransfer the resident			render progressive discipli	- 1		
	1 *	air using the Hoyer			for continued noncomplian			
					The DON or designee will			
		resident was in the			complete the QA audit form	_		
	lift, CNA #8 re	emoved her gloves			F441 at least 5 days per we			
	and washed he	er hands. CNA #3			and bring the results to the interdisciplinary team meti			
	obtained a wir	e and cleansed			the next scheduled mornin			
	_				management meeting that	_		
matter from the right eye of				held at least 5 days per wed				
Resident B, and without changing				In addition, any resident				
	gloves and washing her hands or				changes will be discussed	l l		
	using hand sar	nitizer, CNA #3			weekly at the Standards of			
	_	care supplies from the			Care meeting. These proce and reviews will continue of			
		resident's bedside			ongoing basis. 4.How will	in an		
					corrective action be monitor	ored		
		orushed the resident's	to ensure the deficient practice					
	hair, and place	ed a barrette in the			does not recur and what Q	<u> </u>		
	hair.				will be put into place? The			
					will bring the results of the			
	2 During obs	ervation on 4/5/11 at			audits to the interdisciplina team meeting 5 days per w			
					the weekly Standards of Ca			
	1	A #5 and CNA #14			meeting, the monthly QA&/			
	were observed	transferring and			Committee meeting and to			
	providing inco	ontinent care for			quarterly QA&A Committee	-		
	Resident H. Tl	he CNAs washed			meeting that is attended by medical director for review			
		ned gloves. The			recommendations. The QA			
		ansferred from wheel			audit-441 will be done 5 day	l l		
					week for 30 days, then wee			
	·	nd her wet brief was			for the next 30 days. At tha	t		
	removed. Peri	care was provided by			time, the audit tool will			
	CNA #14. CN	IA #14 then removed			continue at a frequency			
		d without washing			determined by the QA&A Committee, and can be			
	1101 510 105, 411	a miniout musining			Committee, and can be			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155417		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155417	B. WIN			04/05/2011		
NAME OF 1	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE			
HICKOR	Y CREEK AT SCOT	TSBURG		1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)		TAG	discontinued by the QA&A	DATE		
	hands or using hand sanitizer,				Committee when 100%			
		gloves. She applied			compliance is achieved. Th	is		
	barrier cream	to the resident's			process and review of the			
	perineal and a	nal area. CNA #14			24-hour report and review of	I		
	then removed	her gloves, and			the focus charting 5 days p week will continue on an	ei		
		ng hands or using			ongoing basis even when			
		, applied clean			documented audits are no			
					longer required by the QA8	:A		
	gloves. CNA #14 and CNA #5 then				Committee. <u>Date of</u> compliance: May 5, 2011.			
	assisted Resident H to a comfortable position, removed their gloves, and washed their hands.				Addendum to F 441			
					a.) What actions were tak	en		
					for Resident B, Resident	C		
					and Resident H?			
	The facility's p	policy and procedure						
		dwashing and glove			The DON or designee has	s		
		ded by the Director of			observed pericare and			
	_	5/11 at 2:20 p.m. The			personal care being rend			
	1	_			to Residents B, C, and H	·		
	policy was ent				CNA staff at least weekly	as		
	1	g/Alcohol-Based			part of the random			
	Hand Rub" an	d dated as revised			incontinence care			
	7/10. Guidelii	nes indicated, "in			observations that were			
	the absence of	a true emergency,			described in #3 of the pla	n of		
	personnel show	uld always			correction previously			
	1 ^	vash their hands (even			submitted. She or a desig	nee		
	when gloves a	· ·			will observe this care on varied shifts to ensure th	ot		
	_	· ·			each resident has receive			
	promptly and	- ·			appropriate treatment,	u		
	_	contact with blood,			including glove use and			
	1 -	ecretions, excretions,			handwashing. Any identi	fied		
	and equipmen	t or articles			issues will be dealt with a	I		
	contaminated	by them, whether or			described in #3 of the PO			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/05/2011		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE		
	not gloves are are removed; a which microbi hands is likely especiallybo contaminated substances; which indicated to available microorganism and environment indicated betwoen prevent crossedifferent body after each residence.	worn; after gloves after situations during al contamination of to occur, dy fluidsor items with these nen otherwise void transfer of ns to other residents ents;when reen tasks and the same resident to contamination of sites;Before and dent contact;After ident or handling					DATE	